Employee Benefit Services
and Capabilities

### Table of Contents

**Tab 1: NP Dodge Insurance**
- Professional Services

**Tab 2: Plan Strategy Capabilities**
- PlanAdvisor® Fact Sheet
- Sample Benchmark Surveys & Statistics
- Sample Plan Design Educational piece

**Tab 3: Plan Administration and Legislative Compliance**
- Sample Legislative Briefs
- Client Portal Fact Sheet

**Tab 4: Custom Employer/Employee Communications**
- Sample Benefits Bulletin
- Sample Benefits Buzz
- Sample Know Your Employee Benefits
- Sample Live Well, Work Well
- Sample Benefit Statement

**Tab 5: Marketing/Marketing Action Plan**

**Tab 6: Annual Open Enrollment**
- Sample Employee Benefits Enrollment Guide
- Sample Know Your Employee Benefits
- Sample Contribution Change Notice

**Tab 7: Health Care Reform**
- Sample Legislative Briefs

**Tab 8: Maximum Health Solutions**
- Sample Employer Report
- Sample Personal Health Profile

**Tab 9: Wellness Services**
- Sample Wellness Article
- Sample Wellness Tool
Saving money on employee benefits is imperative in today’s economy. The cost of providing benefits continues to rise, and employees consistently seek more. Many employers struggle to balance employee needs with their own bottom lines. Helping you meet these needs is NP Dodge Insurance’s specialty.

Obtaining competitive quotes for coverage and handling claims problems is only a small part of what you should expect from your insurance and employee benefit advisors. We go much further by providing quality services throughout the year. Providing your current carriers with a simple letter that names NP Dodge Insurance as your “Broker of Record” will allow us to complete an in-depth market analysis, obtain quotes from more markets and leverage our relationships with carriers. Brokers typically receive commission dollars from carriers on a monthly basis, which means that your plan renewal dates do not affect your ability to change brokers at any time during your plan year.

Your employees are paying for a portion of your benefit plans, and consequently are paying a portion of your broker’s fees. Ensure that you are providing the best value and service for your company and its employees by working with a quality organization. Our professional employee communications will keep your employees informed, healthy and safe.

In addition to employee communications, our professional services include the following:

- Plan Strategy
- Data Analysis
- Plan Administration and Legislative Compliance (including access to a client portal)
- Employer Education
- Employee Communications
- Wellness Services
NP Dodge Insurance offers the following services to help you offer competitive and cost-effective benefit plan designs:

**PlanAdvisor®**

**Eliminate guesswork from your benefits renewal process.** Our goal is to turn viable solutions into real results through value-added tools that benefit your business. PlanAdvisor offers a simplified way to approach your benefits design planning by balancing both cost and value for your company and employees. We can help you:

- Analyze your benefit plan costs against reliable benchmark information
- Project the impact of medical and dental plan design changes
- Estimate your renewal costs
- Streamline the plan selection process for your employees
- Compare yourself with other employers by region, size and industry

**Benchmark Surveys & Statistics**

Our benchmarking data provides you a standard to which you can compare your benefit programs. We will make recommendations to help you enhance your plan while at the same time remaining competitive and reducing your overall plan costs.

Valuable benefit trend statistics and surveys are one of the core pieces of information that we provide to our clients to help support your benefit plan design strategy and decisions. These surveys and statistics provide benchmark data from leading consulting organizations around the country and cover the following topics:

- Ancillary Benefits
- Benefit Costs
- Benefit Management
- Health Care Costs
- Health Plans
- Prescription Drugs
- Wellness Benefits

**Plan Design**

We offer our clients plan design educational pieces so that they are fully informed when considering their design options.

**Data Analysis**

NP Dodge Insurance has managed medical benefit programs for hundreds of employer groups in an effort to keep costs below comparable levels experienced by other employers. Our aggressive management technique includes a number of internal medical management and preventive health initiatives.

As the health care industry continues to change, we have remained ahead of the game. With leading-edge technology, we obtain meaningful information that helps us evaluate cost drivers,
trends and savings opportunities associated with our clients’ medical benefits. In addition, we work to evaluate the impact of future plan changes.

We provide employer groups with tools that will provide consistent year-to-year data, reporting formats and comparative benchmarks. This highly meaningful – yet understandable – information enables us to work together with your data in a continuous, interactive manner as plan management issues arise.
PlanAdvisor®

What do you See?

At NP Dodge Insurance, we see a simplified way for you to approach the benefits plan design process. With our innovative PlanAdvisor tool, we can help you eliminate the guesswork involved in the benefits renewal process.

Imagine working with us to design a benefits plan that balances both cost and value for your company and its employees. With PlanAdvisor, we can help you to:

- Analyze your benefits plan costs against reliable benchmark information
- Project the impact of medical and Rx plan design changes
- Estimate your renewal costs
- Streamline the plan selection process for your employees

Our goal is to turn trusted solutions into real results. Let us help you with your benefits renewal process. We think you will like what you see.

Compare Your Plan
- Reliable benchmark data from Thomson Reuters MarketScan® Research Databases and Kaiser Family Foundation allows us to compare your plan utilization to other employers of similar plan type, region, and industry
- Uncover cost or utilization concerns
- Access over 40 medical and Rx exhibits based on reliable benchmark data

See Your Plan Options
- Plan modeling based on proven actuarial factors
- Analyze the impact to your company and your employees based on potential plan design changes
- Applies to medical, Rx, HRA and HSA plans

Project Your Plan Costs
- Calculate projected plan costs based on trend, midpoint and large claim information
- Estimate costs mid-year and/or pre-renewal

Simplify the Enrollment Process
- Tool for employees to review estimated predictions and costs for each plan offered
- Helps employees make smart enrollment decisions for their lifestyle and medical needs
- Advances consumerism via employee awareness of costs of services
Average Annual Employer Contribution Toward Single Health Coverage

Average Employer Contribution

<table>
<thead>
<tr>
<th>Year</th>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$4,045</td>
</tr>
<tr>
<td>2008</td>
<td>$3,983</td>
</tr>
<tr>
<td>2007</td>
<td>$3,785</td>
</tr>
<tr>
<td>2006</td>
<td>$3,615</td>
</tr>
<tr>
<td>2005</td>
<td>$3,413</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation, 2009
Health Savings Accounts

In an effort to respond to the rising cost of health insurance, many employers have made use of tax-favored accounts such as health flexible spending accounts (health FSAs), health reimbursement arrangements (HRAs), and medical savings accounts (MSAs) to offer consumer-driven health plans. Beginning in January 2004, the Medicare Prescription Drug Improvement and Modernization Act of 2003 (the Act) created yet another tax-favored account — a health savings account (HSA).

This article will provide answers to commonly asked questions related to HSAs. It highlights guidance issued by the Treasury Department and Internal Revenue Service, as well as recent legislation.

What is a Health Savings Account (HSA)?

An HSA is a tax-exempt¹ trust or custodial account established exclusively for the purpose of paying qualified medical expenses. HSAs are much like Archer Medical Savings Accounts (MSAs), but the rules applicable to HSAs are less restrictive.

Who can establish an HSA?

An individual may contribute to an HSA in any month in which he or she is:

- Covered under a high deductible health plan on the first day of the month,
- Not also covered by another health plan that is not a high deductible health plan (with certain exceptions),²
- Not entitled to benefits under Medicare,³ and
- Not eligible to be claimed as a dependent on another person’s tax return.

Self-employed individuals can be eligible to establish an HSA.

What is a high deductible health plan (HDHP)?

A high deductible health plan (HDHP) is a plan that provides coverage as follows:

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Minimum Annual Deductible</th>
<th>Maximum Annual Out-of-Pocket Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$1,200</td>
<td>$5,950</td>
</tr>
<tr>
<td>Family</td>
<td>$2,400</td>
<td>$11,900</td>
</tr>
</tbody>
</table>

(Calendar Year 2010/2011)

¹ Some states define income differently than the IRS. As a result, HSAs that are tax-exempt at the federal level may not be tax-exempt at the state level.
² For example, accident, dental, vision, long-term care, specific conditions (i.e., cancer-only policies) and hospital indemnity plans.
³ Mere eligibility for Medicare does not make an individual ineligible to contribute to an HSA. An employee that continues to work after attaining age 65 may continue to contribute to an HSA so long as he/she has not enrolled in Medicare. (IRS Notice 2004-50)
How must an HDHP administer the deductible under a family plan?

In addition to establishing minimum annual deductibles for HDHPs, the IRS has also set forth rules governing how the deductible is to be administered.

Most existing health plans administer plans covering a family in a way that includes “stacking the deductible” or an “embedded deductible.” A plan that “stacks deductibles” or has an “embedded deductible” pays claims for a specific individual if he or she has met the individual deductible, although the family as a whole has not met the family deductible.

Example:

Susan, Bob and their dependent elected family coverage under an HDHP. The plan year begins on January 1 and includes a $1,200 individual deductible and a $2,400 family deductible. Susan incurs $2,000 in medical expenses on January 15th. Since the plan has an embedded deductible, Susan is required to pay $1,200 and the plan pays the remaining $800. Although the family deductible was not met, the plan will pay claims for Susan after she has met the individual deductible.

Under the IRS rules, this plan does not qualify as an HDHP since claims were paid before the $2,400 HSA-required family deductible was met.

Example:

Susan, Bob and their dependent elected family coverage under an HDHP. The plan year begins on January 1 and includes a $2,300 individual deductible and a $5,200 family deductible. Susan incurs $3,000 in medical expenses on January 15th. Since the plan has an embedded deductible, Susan is required to pay $2,300 and the plan pays the remaining $700. Although the plan’s family deductible was not met, the plan will pay claims for Susan after she has met the individual deductible.

In this example, the plan complies with the IRS rules and qualifies as an HDHP. The plan includes an embedded deductible, but its minimum individual deductible is equal to the minimum HSA-required family deductible.

An HDHP is not required to include an embedded or stacked deductible. If it does, however, it must comply with the minimum annual deductible requirements explained here.

What is preventive care?

The IRS states that preventive care includes, but is not limited to, the following:

- Periodic health examinations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals;
- Routine prenatal and well-child care;
- Child and adult immunizations;
- Obesity weight loss programs; and
- Screening services.4

---

4 IRS Rev. Ruling 2004-23 clarifies that the screening services for the following conditions are included within the definition of preventive care: cancer, heart and vascular diseases, infectious diseases, mental health conditions and substance abuse, metabolic, nutritional, and endocrine conditions, musculoskeletal disorders, obstetric and gynecologic conditions, pediatric conditions, and vision and hearing disorders.
However, preventive care does not generally include any service or benefit intended to treat an existing illness, injury, or condition.

The IRS provided temporary transitional relief for individuals in states where HDHPs were not available because state laws required fully-insured health plans to provide certain benefits at levels not permitted under an HDHP. For example, some state laws define preventive care more broadly than the IRS. IRS guidance clarified that for purposes of HSAs and corresponding HDHPs, the IRS (not the state) definition of preventive care governs. In order to provide states with time to modify their laws to accommodate HDHPs, the IRS only began enforcing its definition requirement after December 31, 2006.

According to America’s Health Insurance Plan’s (AHIP) Center for Policy and Research 2007 survey, “100 percent [of HSA/HDHP plans offering first-dollar coverage for preventive care outside plan deductibles] cover adult and child immunizations, well-baby and well-child care, mammography, Pap tests and annual physical exams. Nearly 90 percent of policies purchased first-dollar coverage for prostate cancer screenings and more than 80 percent offered this coverage for colonoscopies.” Preventive screenings may also include newborn screenings, children’s vision tests, adult blood pressure and cholesterol tests, women’s bone density testing, colorectal cancer screening, prostate cancer screening for men over 50 and adult screening for depression.

**Can preventive care include prescription drugs?**

Yes. Prescription drugs or medication are preventive care when taken by a person who has risk factors for a disease but is asymptomatic or to prevent the reoccurrence of a disease from which a person has recovered. While HDHPs may cover some prescription drugs like any other preventive care or service, determining on a case-by-case basis whether a prescription drug is taken preventively or to treat an existing condition may be problematic for processors of claims. The IRS also does not consider drugs to be preventive if they “treat an existing illness, injury or condition.” Since it is not always decipherable if medication is taken as a preventive measure, most HSA/HDHP plans do not include prescription drugs as a preventive benefit.

**Must prescription drug benefits be subject to the deductible?**

Yes. Except for prescription drugs that are preventive care, prescription drug benefits covered under an HDHP must be subject to the overall plan deductible. An individual that is covered by an HDHP and a separate prescription drug plan that provides prescription drug benefits after a small copayment is not eligible to contribute to an HSA.

**Who can contribute to an HSA?**

As clarified in IRS Notice 2004-50, any person, including but not limited to the account holder, an employer, or a family member, may make contributions to an HSA on behalf of an eligible individual.

Unlike MSAs, the employer and employee may both contribute to the HSA in the same year, subject to annual contribution limits. However, if an employer makes contributions to any employee’s HSA, the employer must make comparable contributions (that is, the same dollar amount or the same percentage of the HDHP deductible) to the HSAs of all comparable participating employees. “Comparable
participating employees” are eligible individuals who are in the same category of employees (current full time, current part time, or former employees) and who have the same category of HDHP coverage (self only, self plus one, self plus two, or self plus three or more). For the purposes of making a contribution to the HSA of an employee who is not a highly compensated employee (as defined by the IRS), however, highly compensated employees are not treated as comparable participating employees.

An employer may allow employees to contribute pre-tax dollars to the HSA through a Section 125 plan. IRS Notice 2004-50 clarifies that matching contributions made by an employer through a cafeteria plan are not subject to the comparability rule. However, the employer’s contributions are subject to the nondiscrimination rules governing cafeteria plans (i.e., eligibility rules, contributions and benefits tests, and key employee concentration tests). An employer considering matching employee contributions should consult with its cafeteria plan administrator or legal counsel to ensure compliance with these nondiscrimination rules.

**Can an individual make contributions to an HSA when they are also covered under an FSA or HRA?**

Yes. The IRS clarifies how an individual’s participation in an HSA can be coordinated with coverage under an FSA or HRA. The IRS sets forth four examples of acceptable plan coordination:

- Limited Purpose FSA or HRA,
- Post Deductible FSA or HRA,
- Suspended HRA, and
- Retirement HRA.

**What is a Limited Purpose FSA or HRA?**

A Limited Purpose FSA or HRA pays or reimburses Section 213(d) medical expenses that are “permitted coverage” (i.e., dental, vision). For example, an individual that is covered under an HDHP and a Limited Purpose FSA continues to be eligible to contribute to an HSA where the FSA only pays or reimburses expenses for dental or vision care not reimbursed by any other source.

**What is a Post Deductible FSA or HRA?**

A Post Deductible FSA or HRA pays or reimburses medical expenses incurred after the individual has met the minimum annual deductible within the HDHP. For example, an individual may seek reimbursement for amounts paid as copayments or coinsurance, after he or she has met the deductible. Note, however, that funds within an FSA are subject to the use-it-or-lose-it rule. Therefore, in general, an individual will forfeit contributions made to their FSA if they do not meet the deductible during the year.

**What is a Suspended HRA?**

A Suspended HRA, pursuant to an election made before the beginning of the HRA coverage period, does not pay or reimburse at any time, any medical expenses incurred during the suspension period, except preventive care or “permitted coverage.” Once the suspension period ends, the individual is no longer eligible to
contribute to an HSA because the individual is entitled to receive Section 213(d) medical expenses from the HRA.

**What is a Retirement HRA?**

A Retirement HRA pays or reimburses medical expenses incurred after the individual retires. After retirement, the individual is no longer eligible to contribute to an HSA.

**Can an individual be eligible to contribute to an HSA if he/she is also covered under an Employee Assistance Plan (EAP)?**

Yes. An individual will not fail to be eligible to contribute to an HSA merely because the individual is also covered under an EAP, disease management program, or wellness program if the program does not provide significant benefits in the nature of medical care or treatment. An example within IRS Notice 2004-50 clarifies that the availability of short-term counseling, including but not limited to substance abuse, alcoholism, mental health or emotional disorders, does not provide significant benefits in the nature of medical care or treatment.

**Can an individual be eligible to contribute to an HSA if they also purchase a discount card?**

Yes. The IRS states that an individual’s purchase of a discount card does not disqualify him or her from being eligible to contribute to an HSA. The individual must be required to pay for the cost of the services, less the discount, until the deductible is met. For example, an individual may purchase a discount card to purchase prescription drugs or vision care or services.

**Can an individual be eligible to contribute to an HSA if he or she participates in an FSA with a grace period?**

It depends. In IRS Notice 2005-86, the IRS clarified the interaction between the FSA grace period and eligibility to contribute to an HSA. Later legislation and IRS Notice 2007-22 amended this relationship further. In general, coverage by a general purpose health FSA with a grace period would disqualify an individual from contributing to an HSA during the FSA’s grace period, unless the employee had a zero balance in the FSA at the end of the plan year. An FSA can also be amended to allow HSA contributions. Notices 2005-86, 2007-22 and statutory changes made at the end of 2006 provide further guidance regarding participants’ HSA eligibility during the cafeteria plan grace period.

**How much can an individual contribute to an HSA?**

For each month an eligible individual is covered under an HDHP, he or she may contribute 1/12th of $3,050 for individual coverage or $6,150 for family coverage for calendar years 2010 and 2011. Nonetheless, an eligible individual who enrolls in an HSA after the beginning of the plan year is permitted to make a full year’s contribution provided the individual remains covered by the HDHP for at least the 12-month period following that year, except for death or disability.

Further, HSA contributions do not have to be made in equal amounts each month. An eligible individual can contribute in a lump sum or in any amounts or frequency
he or she wishes. However, an account trustee/custodian (bank, credit union, insurer, etc.) can impose minimum deposit and balance requirements.

The HSA contribution limit is reduced by any contributions made to an MSA in the same year. Rollover contributions from another HSA or MSA can be accepted. These rollover contributions are not subject to the annual contribution limit. Additionally, certain one-time rollover contributions from an FSA, HRA or IRA may also be made under statutorily specified conditions.

Individuals that are age 55 or older by the end of the tax year are permitted to make “catch-up contributions.” An additional $1,000 may be contributed to the HSA every year.

What expenses are eligible for reimbursement from an HSA?

An HSA may reimburse qualified medical expenses incurred by the account beneficiary and his or her spouse and dependents. Qualified medical expenses are defined within IRC Sec. 213(d).

In addition to qualified medical expenses, the following insurance premiums may be reimbursed from an HSA:

- COBRA premiums;
- Health insurance premiums while receiving unemployment benefits;
- Qualified long-term care premiums;\(^5\) and
- Any health insurance premiums paid, other than for a Medicare supplemental policy, by individuals age 65 and over.

Distributions made from an HSA to reimburse the account beneficiary for qualified medical expenses are excluded from gross income.

What expenses are not eligible for reimbursement from an HSA?

The following expenses may not be reimbursed from an HSA:

- Premiums for Medicare supplemental policies;
- Expenses covered by another insurance plan; or
- Expenses incurred prior to the date the HSA was established.

Can ineligible expenses be reimbursed from an HSA?

Yes. The trustee is not required to determine if a claim submitted for reimbursement is a qualifying medical expense. The amount withdrawn from an HSA for a non-qualifying medical expense is added to the account beneficiary’s income and subject to a 10% penalty. Where funds are distributed as a result of the account beneficiary’s death, disability, or after he or she is eligible for Medicare, the 10% penalty does not apply.

\(^5\) HSAs may reimburse expenses for qualified long-term care premiums, even where contributions are made by employees with pre-tax dollars through a cafeteria plan. While HSAs may pay or reimburse qualified long-term care premiums, the exclusion from gross income is limited to the adjusted amounts under IRC 213(d)(10).
Who can administer an HSA?

On August 10, 2004, the IRS revised Notice 2004-50 to clarify that insurance companies, banks, or similar financial institutions that have received IRS approval to be a trustee or custodian may administer HSAs. In addition, any other person or organization already approved by the IRS to be a trustee or custodian of IRAs or MSAs is automatically approved to be an HSA trustee or custodian. Unless an employer applies for IRS approval, it may not self-administer an HSA.

Notice 2008-59 further clarifies that any administrative and maintenance fees charged by a trustee or custodian and withdrawn from the HSA are not to be reported as distributions from such HSA. The fair market value of the HSA at the end of the taxable year should also be reduced by the amount of such withdrawn fees.

Where can I find more information on HSAs?

To view the statute, technical guidance and other consumer-friendly information released by the U.S. Department of the Treasury, please visit www.treas.gov/offices/public-affairs/hsa.

HSAs may not be the right solution for all employers or individuals. Please contact your NP Dodge Insurance representative for assistance in determining what tax-advantaged account will best meet your goals.

NP Dodge Insurance welcomes the opportunity to help your organization examine its plan design(s) and make recommendations for improvement.

This copy of Plan Designs is not meant to be exhaustive nor should any discussion or opinions provided be construed as legal advice. Readers seeking legal advice should contact an attorney.

Content © 2004-2010 Zywave, Inc. All rights reserve
Plan Administration and Legislative Compliance

There are countless rules and regulations governing employee benefit plans. Our expert team will help ensure that you are meeting your compliance obligations. We stay up-to-date, and will inform you of any laws or regulations that may affect your employee benefit program. Our compliance consulting services include:

- Easy-to-read Legislative Briefs that summarize recent federal legislative developments in insurance and employee benefits.
- Answers to common COBRA, ARRA, Health Care Reform, FMLA, HIPAA Privacy, Medicare Part D and Section 125 questions.
- Commonly used forms in COBRA, ARRA, FMLA, HIPAA, HIPAA Privacy, Medicare Part D and Section 125 administration.
- A community of knowledgeable colleagues from all over the country to share resources and information via the Community’s interactive forum.
- A variety of insurance, employee benefits and human resources websites and articles, all in one convenient location.

NP Dodge Insurance is committed to helping you with complex plan administration and legislative compliance, using a variety of internal and external resources.

Legislative Briefs
NP Dodge Insurance is happy to provide our clients with exclusive Legislative Briefs publications that summarize recent federal legislative developments in insurance and employee benefits. These informative documents are researched and written in an easy-to-read manner by experienced benefits attorneys.

Community
The Client Portal Community section lets clients network with a vast, knowledgeable group of colleagues from all over the country, and share resources and information. This interactive forum allows you to post questions to peers and provide insight to others’ questions. Topics include Benefits Legislation, Compensation, Employee Relations, Health Care Reform, HR Development, HR Management Topics, Recruitment, Risk Management and Other.

Collaboration Center
The Client Portal’s Collaboration Center allows a seamless exchange of information sharing from our agency to you.

Accessible 24/7, postings from our agency are timely, relevant and easy to locate in one convenient place online.

Surveys
The Client Portal allows all clients to participate in benefit plan surveys, allowing them to determine how their plans and programs compare to other employers across the United States.
The Client Portal also features several value-added services and resources for your human resources and benefits personnel. It facilitates efficient and easy communication with and our clients, and provides a vast array of HR materials, including Legislative information, employee communications, industry-related websites and consumer-related information.

**Resources**
The Client Portal Resources supplies clients with a variety of insurance, employee benefits and human resources websites and articles, all in one convenient location.

**Compliance**
The Legislative Guides give our clients an exclusive set of comprehensive guides to federal legislation. Complete guides include COBRA, FMLA, Health Care Reform, HIPAA, HIPAA Privacy, Medicare Part D and Section 125. Within each guide, sections include Common Questions, Forms and Quick Reference.

**Documents on Command**
Communication materials provide clients with instant access to a library of downloadable articles, including categories such as Wellness Programs, Employee Health & Wellness and Benchmark Surveys & Statistics.

**HealthShop**
Provides our clients with HealthShop – comprehensive consumer information in a ready-to-print newsletter format. Topics include At the Doctor’s Office, At the Pharmacy, Home Care and Your Health Plan.

The following are examples of the legislative and state-specific compliance information we offer our clients, along with a fact sheet that describes the client portal in detail.
Legislative Brief

COBRA Premium Subsidy: The American Recovery And Reinvestment Act of 2009

On February 17, 2009, President Obama signed into law H.R. 1, the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA expanded the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage to provide a 65 percent federal subsidy toward an eligible worker’s COBRA premium for up to 9 months.

The premium subsidy period was extended to 15 months in December, 2009. On March 2, 2010, the Temporary Extension Act of 2010 extended the eligibility period for the subsidy through March 31, 2010.

Please read below for more information on the COBRA subsidy and contact your NP Dodge Insurance representative with any questions.

What is the COBRA Subsidy?

Eligible individuals may receive a 65 percent subsidy toward their COBRA continuation premium for up to 15 months. Employers or health plans that administer COBRA benefits will receive a credit against payroll taxes for the cost of the subsidy. The subsidy may terminate before the end of the 15 month period if the individual becomes eligible for any new employer-sponsored health care coverage or Medicare coverage.

For What Coverage is the Subsidy Available?

The federal subsidy is available for COBRA continuation coverage and for state programs providing comparable continuation coverage (State “mini-COBRA” programs). The subsidy is not available for coverage under a health flexible spending arrangement.

Who is Eligible for the COBRA Subsidy?

Individuals who are involuntarily terminated from employment between September 1, 2008 and March 31, 2010, and make a timely election of COBRA, are eligible for the COBRA premium assistance subsidy, along with their dependents. In addition, under the most recent extension, employees who lost coverage due to a reduction in hours of employment and were later involuntarily terminated from March 2, 2010 through March 31, 2010 are eligible for the premium subsidy.

The full subsidy is available to individuals who have annual incomes of less than $125,000 (single) or $250,000 (joint filers) for the taxable year in which the subsidy is received. If the premium subsidy is provided to an individual whose income exceeds $145,000 (single) or $290,000 (joint), then the amount of the premium subsidy for all months during the taxable year must be repaid. For taxpayers with income between $125,000 and $145,000 (or $250,000 and $290,000 for joint filers), the amount of the premium subsidy for the taxable year that must be repaid is reduced proportionately.

Note that, although the involuntary termination of employment is the qualifying event for purposes of subsidy eligibility, the reduction in hours itself is still the qualifying event for determining the maximum COBRA coverage period.
Are Individuals Whose 9-Month Premium Subsidy Expired Eligible for the 15-Month Subsidy Extension?

Yes, these individuals are eligible to receive the subsidy for the full 15 months. They must be given the opportunity to continue their coverage, retroactively, if they had let their coverage lapse because they thought the subsidy was ending. They must pay the 35 percent of premium costs by the later of February 17, 2010, 30 days after notice of the extension is provided, or the plan’s normal payment deadline.

Do Any Special Enrollment Rights Exist?

Federal COBRA law provides that a group health plan must allow an eligible individual to choose to continue with the coverage in which the individual is enrolled as of the qualifying event. However, ARRA allows group health plans to provide a special enrollment right to allow eligible individuals to elect different coverage under the plan in electing COBRA continuation coverage. Further, even though the premium subsidy is only for 15 months, the different coverage elected must generally be permitted to be continued for the applicable required period (generally 18 months or 36 months, absent a COBRA terminating event).

Also, qualified individuals who initially declined COBRA coverage prior to the enactment of ARRA were given an additional 60 days after they received notice of the special election period to elect COBRA coverage and receive the subsidy. The election period began on the date of enactment of ARRA. The special election opportunity was also available to a qualified beneficiary who elected COBRA coverage but who was no longer enrolled on the date of enactment, for example, because the beneficiary was unable to continue paying the premium.

Under the most recent extension, qualified individuals who were eligible for COBRA due to a reduction of hours of employment, but did not make (or made and discontinued) an election of continuation coverage and were later involuntarily terminated are eligible to elect COBRA coverage and receive the premium subsidy. These individuals must be given, during the 60-day period beginning on the date of such individual’s involuntary termination of employment, an additional notification of their eligibility to elect COBRA.

What Are the Notice Requirements?

ARRA, as amended, mandates the provision of certain notices. As part of the COBRA election notice, plan administrators must provide information about the premium reduction to all individuals who have COBRA qualifying events from September 1, 2008 through March 31, 2010. The Department of Labor issued model notices to help plans and individuals comply with these requirements. Each model notice is designed for a particular group of qualified beneficiaries and contains information to help satisfy ARRA’s notice provisions. The model notices have not yet been updated to reflect the most recent extension and may need to be modified before use.

How is the Subsidy Administered?

The subsidy is generally administered as a reimbursement. The entity to which premiums are payable will be reimbursed by the amount of the premium for COBRA coverage that is not paid by an eligible individual on account of their 65 percent premium reduction. An entity is not eligible for subsidy reimbursement, however, until it has received the reduced premium payment from the eligible individual. The entity to whom the federal reimbursement is payable is either (1) the multiemployer group health plan, (2) the employer maintaining the group health plan subject to federal COBRA, or (3) the insurer providing coverage under an insured plan.

The entity that is eligible for reimbursement may elect to offset its payroll taxes for purposes of reimbursement. To the extent that such entity has liability for income tax withholding from wages or FICA
Legislative Brief

COBRA Premium Subsidy: The American Recovery And Reinvestment Act of 2009

taxes with respect to its employees, the entity is reimbursed by treating the amount that is reimbursable to the entity as a credit against its liability for these payroll taxes. That is, the credit for the reimbursement is treated as a payment of payroll taxes. Any reimbursement for an amount in excess of the payroll taxes owed is treated in the same manner as a tax refund. Entities wishing to claim reimbursements will be required to file certain reports, including an attestation of the involuntary termination of employment of each covered employee for which reimbursement of premiums is claimed.

Is the Subsidy Retroactive?

Although the subsidy is available to employees who were terminated starting September 1, 2008, the subsidy itself is not retroactive. It will apply only to periods of coverage beginning on or after March 1, 2009.

What Compliance Actions Should Be Taken Now?

In addition to the initial steps taken to comply with ARRA, the following action should be taken to ensure continued compliance:

- Timely notify employers and family members of their rights under ARRA, including changes made by new rules;
- Monitor employees that experienced a reduction in hours and maybe involuntarily terminated; and
- Implement procedures for a special election period for individuals who lost coverage because of a reduction in hours, did not elect COBRA (or discontinued an election) and are later involuntarily terminated from March 2, 2010 through March 31, 2010.

Where Can I Get More Information?

For a copy of the COBRA premium reduction provision of ARRA, see: www.dol.gov/ebsa/pdf/COBRAPremiumReductionProvision.pdf

For a fact sheet describing the COBRA premium reduction extension, see: www.dol.gov/ebsa/newsroom/fscobrapremiumreduction.html

For copies of the DOL model forms, see: www.dol.gov/ebsa/COBRAmodelnotice.html

For general information regarding COBRA, see: www.dol.gov/dol/topic/health-plans/cobra.htm or www.irs.gov/newsroom/article/0,,id=204505,00.html Your NPD, Inc. representative is also available to assist you with any questions.

(3/09; KMP 3/10)

This NP Dodge Insurance Legislative Brief is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.
Welcome to a whole new way of working — MyWave® is your personalized website that allows you to effortlessly click, connect and communicate with NP Dodge Insurance.

It’s designed to offer you time-saving tools and resources that build convenience into managing your everyday work tasks. Whether you want to view documents online, participate in plan/program surveys or connect with around 400,000 peers in your industry, this is the place to be. It’s easily accessible, hardworking and just one of the many value-added services available to you when you partner with us.

"The Community section allows us to easily find out what other companies are doing in a variety of situations. I can get answers quickly from other colleagues in the industry; the Community has become my personal sounding board."

Trevor, MyWave Portal User, Northeast
Understanding the complexity of employee benefits plans is a challenge even for experienced benefits managers. Employers need to keep abreast of constantly changing trends, laws and other regulations. Employees need to be able to understand their benefits well in order to be wise consumers and understand the value of their “hidden paycheck.” Unfortunately, most employers have limited resources in this area.

The team helps you tackle your employee communication challenges. With strategic planning and a thorough understanding of your communication objectives, we provide custom communication materials that will help both you and your employees understand your plans and the issues influencing your benefits decisions. Below are the types of custom communications we offer – with a few samples included.

**Employee Benefit Communications**
Benefit communications include memos, flyers, payroll stuffers, posters and articles used to announce benefit changes, introduce new benefits or plans, or to help employees understand and use certain benefits.

**Benefit Statements**
We provide benefit statement items such as total compensation statement packets and a summary of an employee’s benefits package, including salary and benefits.

**Consumer-Directed Health Care (CDHC)**
We supply everything you need, including letters, flyers, articles, payroll stuffers, posters and e-mails to help support your CDHC campaigns.

**Employer Education Articles and Newsletters**
You’ll have access to educational articles covering hot benefit topics. This also includes a quarterly Benefits Bulletin newsletter about the newest legislation issues and benefits trends, along with a monthly one-page newsletter covering highlights of current HR and benefit news.

**Employee Handbook & Policies**
Access a full employee handbook, as well individual policies, that you can provide to your employees to communicate company policies or procedures.

**Health Awareness Newsletter**
This monthly, customized, two-page newsletter for your employees covers various health and wellness topics.
Know Your Employee Benefits
Provide your employees with insight and information about insurance and employee benefits topics with this series. These brochures help your employees better understand their benefits, and can serve as a foundation for your ongoing employee communication campaigns.

Live Well, Work Well
This series of flyers centers on health and wellness issues, educating employees on how to live healthy and productive lives.

National Health Observances Calendar
The NHO Calendar allows you to educate and inform your employees on wellness issues throughout the year by supplying you with national health observances and listings of materials that complement those observances.

Prevention Newsletter
This quarterly newsletter focuses on topics such as obesity, exercise, drug and alcohol prevention, the flu and much more.

Retirement
The documents included in our Savings Fitness and Know Your Retirement Benefits series will help your employees adequately prepare for their golden years.
Health Care Reform Timeline

On March 23, 2010, President Obama signed into law the health care reform bill, the Patient Protection and Affordable Care Act. This legislation, along with the Health Care and Education Reconciliation Act of 2010, makes sweeping changes to the U.S. health care system. These changes will be implemented over the next several years.

2010

**Expanded Insurance Coverage**
- **Extended Coverage for Young Adults.** Group health plans and health insurance issuers offering group or individual health insurance coverage that provides dependent coverage of children must make coverage available for adult children up to age 26. There is no requirement to cover the child of a dependent child. This requirement will apply to grandfathered and new plans.
- **Access to Insurance for Uninsured Individuals with Pre-Existing Conditions.** The health care reform bill provides for the establishment of a temporary high risk health insurance pool program to provide health insurance coverage for certain uninsured individuals with pre-existing conditions. The program will end when the health insurance exchanges, set to be established in 2014, are operational.
- **Identifying Affordable Coverage.** The Secretary of Health and Human Services is required to establish an Internet website through which residents of any state may identify affordable health insurance coverage options in that state. The website will also include information for small businesses about available coverage options.
- **Reinsurance for Covering Early Retirees.** The new law requires the establishment of a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees and their spouses, surviving spouses and dependents. This program will end on January 1, 2014.

**Health Insurance Reform**
- **Eliminating Pre-Existing Condition Exclusions for Children.** Group health plans and health insurance issuers may not impose pre-existing condition exclusions on coverage for children. This provision will apply to all employer plans and new plans in the individual market. This provision will also apply to adults in 2014.
- **Coverage of Preventive Health Services.** Group health plans and health insurance issuers offering group or individual health insurance coverage must provide coverage for preventive services. These plans also may not impose cost sharing requirements for preventive services.
- **Prohibiting Rescissions.** The health care reform law is designed to prohibit abusive rescissions of coverage by insurance companies when an individual gets sick as a way of avoiding covering the cost of the individual’s health care needs. Group health plans and health insurance issuers offering group or individual insurance coverage may not rescind coverage once the enrollee is covered, except in cases of fraud or intentional misrepresentation. Plan coverage may not be cancelled without prior notice to the enrollee. This provision applies to all new and existing plans.
- **Limits on Lifetime and Annual Limits.** In general, group health plans and health insurance issuers offering group or individual health insurance coverage may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary or impose unreasonable annual limits on the dollar value of benefits for any participant or
beneficiary. This requirement applies to all plans. Annual limits will also be prohibited beginning in 2014.

**Health Plan Administration**

**Improved Appeals Process.** Group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective appeals process for appeals of coverage determinations and claims. At a minimum, plans and issuers must:
- have an internal claims process in effect;
- provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist them with the appeals processes; and
- allow enrollees to review their files, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

The internal claims process must initially incorporate the current claims procedure regulations issued by the Department of Labor in 2001. Plans and issuers must also implement an external review process that meets applicable state requirements and guidance that is to be issued.

**Nondiscrimination Rules for Fully-Insured Plans.** Fully-insured group health plans will now have to satisfy nondiscrimination rules regarding eligibility to participate in the plan and eligibility for benefits. These rules prohibit discrimination in favor of highly compensated individuals. This section does not appear to apply to grandfathered plans.

**Medicare/Medicaid**

**Rebates for the Medicare Part D “Donut Hole.”** Currently, there is a gap in Medicare prescription drug coverage. The coverage gap falls between $2,830 and $6,440 in total drug spending. The health care reform bill provides a $250 rebate check for all Medicare Part D enrollees who enter the “donut hole.” Beginning in 2011, a 50 percent discount on brand-name drugs will be instituted and generic drug coverage will be provided in the donut hole. The donut hole gap will be filled by 2020.

**Medicaid Flexibility for States.** States are given a new option under the health care reform law to cover additional individuals under Medicare. States will be able to cover parents and childless adults up to 133 percent of the Federal Poverty Level (FPL).

**Fees and Taxes**

**Small Business Tax Credit.** The first phase of the small business tax credit for qualified small employers begins in 2010. These employers can receive a credit for contributions to purchase health insurance for employees. The credit is up to 35 percent of the employer’s contribution to provide health insurance for employees. There is also up to a 25 percent credit for small nonprofit organizations. When health insurance exchanges are operational, tax credits will increase, up to 50 percent of premiums.

2011

**Expanded Insurance Coverage**

**Voluntary Long-Term Care Insurance Options.** The health care reform law creates a long-term care insurance program for adults who become disabled. Participation will be voluntary and the program is to be funded by voluntary payroll deductions to provide benefits to adults who become disabled.

**Health Plan Administration**

**Improving Medical Loss Ratios.** Health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans) must annually report on the share of premium dollars spent on health care and provide consumer rebates for excessive medical loss ratios.

**Reporting Health Coverage Costs on Form W-2.** Beginning in 2011, employers will be required to disclose the value of the health coverage provided by the employer to each employee on the employee’s annual Form W-2.

**Standardizing the Definition of Qualified Medical Expenses.** The health care reform law conforms to the definition of “qualified medical expenses” for HSAs, FSAs and HRAs to the definition used for the itemized tax deduction. An exception to this rule is included so that amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses. Costs for over-the-counter medications obtained without a prescription would not qualify.

**Cafeteria Plan Changes.** The new law creates a Simple Cafeteria Plan to provide a vehicle through which small businesses can provide tax-free benefits to their employees. This plan is designed to ease the small employer’s administrative burden of sponsoring a cafeteria plan. The provision also exempts employers who make contributions for employees under a simple cafeteria plan from pension plan nondiscrimination requirements applicable to highly compensated and key employees.
Medicare/Medicaid

- **Medicare Part D Discounts.** In order to make prescription drug coverage more affordable for Medicare enrollees, the new law will provide a 50 percent discount on all brand-name drugs and biologics in the “donut hole.” It also begins phasing in additional discounts on brand-name and generic drugs to completely fill the donut hole by 2020 for all Part D enrollees.

- **Additional Preventive Health Coverage.** The new law provides a free, annual wellness visit and personalized prevention plan services for Medicare beneficiaries and eliminates cost-sharing for preventive services beginning in 2011.

Fees and Taxes

- **Increased Tax on Withdrawals from HSAs and Archer MSAs.** The health care reform law will increase the additional tax on HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses would increase from 15 to 20 percent.

2013

Health Plan Administration

- **Administrative Simplification.** Beginning in 2013, health plans must adopt and implement uniform standards and business rules for the electronic exchange of health information to reduce paperwork and administrative burdens and costs.

- **Limiting Health Flexible Savings Account Contributions.** The new health care law will limit the amount of contributions to health FSAs to $2,500 per year, indexed by CPI for subsequent years.

Fees and Taxes

- **Eliminating Deduction for Medicare Part D Subsidy.** Currently, employers that maintain prescription drug plans for their Medicare Part D eligible retirees are entitled to a tax deduction. This deduction will be eliminated in 2013.

- **Increased Threshold for Medical Expense Deductions.** The health care reform law increases the income threshold for claiming the itemized deduction for medical expenses from 7.5 percent of income to 10 percent. However, individuals over 65 would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.

- **Additional Hospital Insurance Tax for High Wage Workers.** The new law increases the hospital insurance tax rate by 0.9 percentage points on wages over $200,000 for an individual ($250,000 for married couples filing jointly). The tax is also expanded to include a 3.8 percent tax on net investment income in the case of taxpayers earning over $200,000 ($250,000 for joint returns).

- **Medical Device Excise Tax.** The law also establishes a 2.3 percent excise tax on the first sale for use of a medical device. Eye glasses, contact lenses, hearing aids, and any device of a type that is generally purchased by the public at retail for individual use are excepted from the tax.

2014

Coverage Mandates

- **Individual Coverage Mandates.** The health care reform legislation requires most individuals to obtain acceptable health insurance coverage or pay a penalty, beginning in 2014. The penalty will start at $95 per person for 2014 and increase each year. The penalty amount increases to $325 in 2015 and to $695 (or up to 2.5 percent of income) in 2016, up to a cap of the national average bronze plan premium. After 2016, dollar amounts are indexed. Families will pay half the penalty amount for children, up to a cap of $2,250 per family. Individuals may be eligible for an exemption from the penalty if they cannot obtain affordable coverage.

- **Employer Coverage Mandates.** Employers with 50 or more employees that do not offer coverage to their employees will be subject to penalties if one employee receives a government subsidy for health coverage. The penalty amount is up to $2,000 annually for each full-time employee, excluding the first 30 employees. Employers who offer coverage, but whose employees receive tax credits, will be subject to a fine of $3,000 for each worker receiving a tax credit, up to an aggregate cap of $2,000 per full-time employee. Employers will be required to report to the federal government on health coverage they provide.
Health Insurance Exchanges
The health care reform legislation provides for **health insurance exchanges** to be established in each state in 2014. Individuals and small employers will be able to shop for insurance through the exchanges. Small employers are those with no more than 100 employees. If a small employer later grows above 100 employees, it may still be treated as a small employer. Large employers with over 100 employees are to be allowed into the exchanges in 2017. Workers who qualify for an affordability exemption to the coverage mandate, but do not qualify for tax credits, can use their employer contribution to join an exchange plan.

Health Insurance Reform
Additional **health insurance reform** measures will be implemented beginning in 2014. Specifically, health insurance companies will not be permitted to:

- Refuse to sell or renew policies due to an individual’s health status;
- Exclude coverage for treatments based on pre-existing health conditions;
- Charge higher rates due to health status, gender or other factors (premiums will be able to vary based only on age (no more than 3:1), geography, family size, and tobacco use);
- Impose annual limits on the amount of coverage an individual may receive; or
- Drop coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases or deny coverage for routine care that they would otherwise provide just because an individual is enrolled in such a clinical trial.

Fees and Taxes
- **Individual Health Care Tax Credits.** The new law makes premium tax credits available through the exchanges to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below 400 percent of poverty level who are not eligible for or offered other acceptable coverage. The credits apply to both premiums and cost-sharing.
- **Small Business Tax Credit.** The second phase of the small business tax credit for qualified small employers will be implemented in 2014. These employers can receive a credit for contributions to purchase health insurance for employees, up to 50 percent of premiums.
- **Health Insurance Provider Fee.** The health care reform law imposes an annual, non-deductible fee on the health insurance sector, allocated across the industry according to market share. The fee does not apply to companies whose net premiums written are $25 million or less.

2018

High-Cost Plan Excise Tax
A 40 percent excise tax is to be imposed on the excess benefit of high cost employer-sponsored health insurance (also known as a “Cadillac tax”). The annual limit for purposes of calculating the excess benefits is $10,200 for individuals and $27,500 for other than individual coverage. Responsibility for the tax is on the “coverage provider” which can be the insurer, the employer, or a third-party administrator. There are a number of exceptions and special rules for high coverage cost states and different job classifications.

FMLA Fraud – An Employer Concern
Every year the Family and Medical Leave Act (FMLA) helps employees across the nation manage serious health issues and care for ill family members. With this comes a major frustration for employers – the suspected abuse or direct appearance of an employee using this leave inappropriately under FMLA. In fact, suspected employee abuse is the number one FMLA-related concern for employers – with more than 60 percent believing they have granted unfounded leave to employees in the past.

**Signs Indicating Possible Abuse**
- Frequent leave requests immediately preceding or following a weekend
- FMLA leave requests after denial of vacation on the same or similar days
- Very sudden or abrupt leave requests
- Increase in the number of leave requests
- Complaints from other employees that an individual is abusing leave
• Sightings of an employee on leave engaged in strenuous activities, or activities indicating the employee is capable of performing his/her job
• Repeated injuries/re-injuries shortly after returning from leave

**Tips to Prevent and Head Off Abuse**

• Require employees to use all paid leave before taking unpaid FMLA. Employees are less likely to abuse FMLA if they have to use up vacation time before doing so.
• Obtain medical certification directly from the doctor. The Seventh Circuit Court has held that an employer does not interfere with FMLA rights by requiring that the completed certification form be faxed or mailed directly by the doctor.
• Require medical certifications within 15 days of taking leave. Employers that are specific about the documentation needed to take FMLA leave as well as the penalties for not complying have a much easier time taking action if the employee fails to do so.
• Have employees provide notice for expected FMLA leave. Requiring advance notice gives the employer the time to plan around future absences, minimizing abuse.
• Establish attendance and call-in policies for all leave. Consistent enforcement of leave policies, including FMLA, can be designed to prevent fraud.
• Utilize private investigators if necessary. Courts have been reluctant to rule against an employer for terminating an employee when he/she is caught directly engaging in fraud.
• Obtain “fitness for duty” certifications for employees when they return from FMLA leave. However, this cannot be required of an employee if returning from intermittent FMLA leave.
• Establish a policy prohibiting an employee from working a second job while on FMLA leave. Note that the Sixth Circuit Court in 2003 ruled that there may be instances when an employee can lawfully take FMLA leave from an employer and still work a second job, and some state FMLA laws may also allow this practice.

**Ways to Obtain Additional Medical Information if Fraud is Suspected**

• Employers can directly contact employees’ health care providers without the employees’ permission to make certain that the health care provider is the person who actually signed the certification form.
• Clarifications regarding certification forms can be acquired from the health care provider, but only within the confines of the privacy rules of the Health Insurance Portability and Accountability Act.
• An employer may request the opinion of a second or third health care provider designated or approved by the employer, but not employed regularly by them. This will be at the employer’s own expense.
• An employer is not required to obtain additional opinions and may deny the FMLA leave without a second or third opinion when the employer has credible reason to doubt the validity of the certification.
• An employer may request a recertification of the medical condition associated with the employee’s absence every six months. If the employer has reason to doubt the employee’s stated reason for leave, it may request recertification in 30 days or even less.

In order to minimize FMLA fraud in the workplace, measures can be taken by the employer without violating an employee's FMLA rights. By detecting possible signs of abuse, using tips to prevent abuse and obtaining additional medical information when fraud is suspected, you take effective steps as an employer toward eliminating FMLA abuse at your workplace.

**New Requirements for Mental Health and Substance Use Disorder Coverage**

On February 2, 2010, interim final rules regarding coverage for treatment of mental health and substance use disorders were issued. The new rules implement the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and apply to employers with 50 or more workers who choose to offer mental health or substance use disorder benefits in a group health plan. Below is an overview of the parity requirements:
The Laws
The MHPAEA and the Mental Health Parity Act of 1996 (MHPA) together require parity between medical/surgical benefits and mental health or substance use disorder (MH/SUD) benefits with respect to aggregate lifetime and annual dollar limits, financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits). The MHPAEA and MHPA do not mandate that a plan provide MH/SUD benefits. Rather, if a plan provides medical/surgical and MH/SUD benefits, it must comply with the laws’ parity provisions.

The laws apply to plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully-insured arrangements. The laws also apply to health insurance issuers who sell coverage to employers with more than 50 employees.

What Are Some of the New Rules Plans Need to Consider?
Financial Requirements – The general parity requirements are extended to financial requirements, such as co-pays and co-insurance.
Deductibles - Combined deductibles are required for MH/SUD benefits and medical/surgical benefits. Separate deductibles are now prohibited. That is, a plan may not apply one deductible to MH/SUD benefits and another deductible to medical/surgical benefits.
MH/SUD Benefits - So that benefits are not misclassified, plans must use generally recognized independent standards of current medical practice in defining whether benefits are MH/SUD benefits.
Treatment Limitations - Both quantitative (e.g., visit limits) and nonquantitative (e.g., medical management standards) treatment limitations are subject to the parity requirements.
Coverage Units - Plans must apply parity requirements for financial requirements and treatment limitations based on each “coverage unit” (e.g., self-only, family, and employee plus spouse).
Prescription Drugs - Plans are permitted to divide prescription drug coverage into tiers and apply the parity requirements separately to each tier of drug coverage based upon reasonable factors such as cost, generic versus brand name, and mail order versus pharmacy pick up.
Disclosures – Disclosures from ERISA plans can follow existing requirements. Plans not subject to ERISA must provide disclosures within a reasonable time and in a reasonable manner.
Exemptions - If applicable, the increased cost exemption can only be claimed for alternating years.

Steps to Take Now
Plan sponsors should become familiar with the interim final regulations and review their health plans. It is likely that additional plans may now be subject to the parity requirements. Plans will need to evaluate whether any substantive changes must be made to their plan designs, such as providing for a combined deductible. Plans will also need to review their administration of benefits in order to ensure that administrative procedures are in compliance by the regulatory deadline.

Please contact your NPD, Inc. representative for more information.
10 Easy Ways to Stretch Your Health Care Dollars

You can hardly turn on the nightly news or pick up a newspaper without hearing about the rising cost of health care and the stifling effect it is having on individuals and employers. With experts predicting national health care cost increases to stay in the double-digits for the near and long-term, employers are passing more costs on to their employees, and individuals and families are looking for ways to stretch their health care dollars.

Stretching your health care dollars is easier than you think. Below are 10 ways you can easily do your part to help keep overall health care costs down.

1. **Understand how your health plan works.** This is probably the first and most important step in getting the most for your health care dollar. You need to know what is and what is not covered, what procedures you need to follow to ensure your claims are paid, and which providers and facilities to use to get the most cost-effective care. Know the deductibles, copayments, and other out-of-pocket costs you are responsible for paying before you use medical products or services or get a prescription filled.

2. **Use in-network providers.** Participating providers (doctors, hospitals, and other providers in your plan’s network) generally charge discounted rates for plan members. When you go to a non-participating provider you will likely pay a higher coinsurance percentage (for example, 30 percent out-of-network versus 10 percent in-network). And, you will likely have to pay the difference in price between the participating provider’s discounted fee and the non-participating provider’s “regular” fee.

3. **Look into freestanding surgical and diagnostic centers.** If you need surgery, you might save money by having it performed at an ambulatory surgical center (a clinic that is not associated with a hospital.) These sites usually charge less than hospitals or their outpatient surgical centers. Freestanding diagnostic centers are also available and tend to charge less for certain tests like MRIs, CAT scans, X-rays, and bone density scans. But before you go, make sure the facility is in your plan’s network and that your plan’s benefits cover the service. As always, talk to your doctor to be sure this course of action is appropriate for you.

4. **Ask your doctor about home testing and monitoring devices.** Home tests for blood pressure, diabetes and other conditions can help ensure you are following your doctor’s orders and that prescribed treatments are working. These tests will usually cost less than in-office testing. Check with your doctor to be sure in-home testing is appropriate, report your results regularly and call your doctor if you notice anything unusual.

5. **Only go to the hospital emergency room for true emergencies.** If you need medical care when your regular doctor is not available, think about going to an urgent care center rather than a hospital emergency room. This can often be a tough call, but for a cold or a minor sprain, avoiding the ER will probably save you money for two reasons: 1) the copayment is usually lower for a doctor visit or an urgent care visit, and 2) your insurer might make you pay for the full cost of care if you use an emergency room for a non-emergency. Plus, getting care at an urgent care center will almost certainly be faster than at the ER. Call your plan’s health hotline, if available, to get advice on
how, when, and where to seek care in a non-emergency situation.

6. **Carefully check all medical bills.** Insurance companies and hospitals are not exempt from making billing errors. Insurers often miscalculate the family deductible, so keep a careful tally of individual as well as total family payments to be sure you don’t pay too much. If you have a hospital stay, try to keep a log of all the services, medications, and supplies you are given, so when you get a bill you can be sure you are not charged for procedures you didn’t have or items you didn’t use. Ask for an itemized bill.

7. **Use any additional programs or discounts provided by your employer or health plan.** Many health plans provide access to free disease management programs for chronic conditions like asthma, diabetes and heart disease. These programs can help you stay healthy and manage your condition, and can possibly save you money in the long run. In addition, many employers offer complementary programs that are designed to prevent illness and lower health costs over the long run. These programs may include smoking cessation and weight loss programs, or discounts on fitness clubs or other items that help you live a healthy lifestyle.

8. **Live a healthy lifestyle.** Healthy habits like exercising regularly, eating well, and not smoking can increase your stamina, lighten your mood, and lower your risk for certain diseases. Aside from the physical and psychological benefits, healthy living can also offer financial rewards, such as lower premiums for non-smokers and fewer doctor visits for those with low blood pressure.

9. **Make careful decisions about prescription drugs.** Prescription drugs are the fastest rising area of health care costs and one of the biggest reasons behind dramatic increases in health care costs nationwide. Here are some ways you can reduce your prescription drug costs:
   - **Use generic drugs whenever possible, even for over-the-counter medications.** Remember, the most expensive drug is definitely not the best. There are usually generic equivalents that are less expensive than the drugs you see advertised on TV. Before your physician writes you a prescription, ask about generic equivalents, lower-cost brand name drugs to treat the same condition, and even over-the-counter options.
   - **Know how your drug plan works.** Check your copayments and know the maximum amount your plan will pay for in one year. Find out if your plan has a formulary (a list of preferred drugs that are covered). A health plan with a closed formulary pays only for certain pre-approved drugs. A plan with an open formulary will cover most drugs but at varying prices.
   - **Use a mail order pharmacy if one is available.** Ordering prescriptions by mail can save 10–15 percent and is perfect for patients who take medication on an ongoing basis and can place orders in advance.
   - **Talk to your doctor.** Make sure your physician knows if you have to pay for your prescriptions out of your own pocket. Often there are less expensive but equally effective treatment options.
   - **Compare prices.** Shop around for the pharmacy that offers the best value for your needs. You may even need to get different medications from different pharmacies depending on which offers a better price.
   - **Consider pill-splitting.** Some medications can be obtained at double the prescribed dose, and then split in half. This practice can result in 50 percent savings. But, you must be sure your medication is appropriate for splitting, so talk to your doctor first. Some medications require very precise dosing, and others simply cannot be split effectively or accurately.
- Look into manufacturer aid programs. Most major drug manufacturers have programs to subsidize patients who are not able to pay for medications they need. All of these programs require your doctor to apply for you.

- Take all medications as prescribed. Not refilling your prescription might seem like a good way to save money, but it may in fact cost you more money in the long run. Many drugs, when taken as directed, keep you from needing expensive medical care or hospitalization.

10. Use a health care spending account to pay for medical expenses with pre-tax money. If your employer provides you access to a Flexible Spending Account (FSA) or Health Savings Account (HSA), use it. These accounts let you set aside pretax money from your paycheck to pay for eligible items like prescription drugs and over-the-counter medications, deductibles, coinsurance, dental expenses and vision care. You get to save for these expenses gradually, rather than having the money in your checking account when the need arises. And, because you don’t pay taxes on the money, you are actually getting a “percent off” or a discount on everything you purchase with your saved money. For example, assuming the government takes 20 percent of your income, and you put $500 in your health care spending account, you save about $100 in taxes.

Health care costs are tied directly to utilization; when you use your health plan more, there are more claims. And the higher the claims, the more you and your employer must contribute to pay for these claims. Don’t forget that the most cost effective way to reduce the cost of health care is to make better decisions about the way you live, including the way you eat, exercise, and spend your health care dollars.

This brochure is for informational purposes only and is not intended to replace the advice of an insurance professional.

Know Your Employee Benefits is written and produced for NP Dodge Insurance. Content © 2007-2010 Zywave, Inc. All rights reserved.
Understanding a Health Savings Account

What is a health savings account?
Otherwise known as an HSA, a health savings account can be funded with your tax-exempt dollars, by your employer, or both, to help pay for eligible medical expenses not covered by an insurance plan, including the deductible, coinsurance, and even in some cases, health insurance premiums.

Who is eligible for an HSA?
Anyone who is:
- Covered by a High Deductible Health Plan (HDHP);
- Not covered under another medical plan that is not an HDHP;
- Not entitled to Medicare benefits; or
- Not eligible to be claimed on another person’s tax return.

What is a High Deductible Health Plan (HDHP)?
A High Deductible Health Plan is a plan with a minimum annual deductible and a maximum out-of-pocket limit as listed below. These minimums and maximums are determined annually by the Internal Revenue Service (IRS) and are subject to change.

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Minimum Annual Deductible</th>
<th>Maximum Annual Out-of-Pocket</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$1,200</td>
<td>$5,950</td>
</tr>
<tr>
<td>Family</td>
<td>$2,400</td>
<td>$11,900</td>
</tr>
</tbody>
</table>

(2010/2011 limits)

How Does an HSA Work?

Part 1: Qualifying High Deductible Health Insurance Plan

Intended to cover serious illness or injury after the deductible has been met.

Part 2: Health Savings Account

Pays for out-of-pocket expenses incurred before the deductible is met.
What are the steps in an HSA?

1. Employee and/or employer funds HSA account.
2. Employee seeks medical services.
3. Medical services are paid by HDHP, subject to deductible and coinsurance.
4. Employee may seek reimbursement from HSA account for amounts paid toward deductible and coinsurance.
5. Deductible and out-of-pocket maximum fulfilled.
6. Employee may be covered for all remaining eligible expenses.*

Preventive care may be covered at 100%

*Subject to plan design; check Summary Plan Description.

When do I use my HSA?
After visiting a physician, facility or pharmacy, your medical claim will be submitted to your HDHP for payment. Your HSA dollars can be used to pay your out-of-pocket expenses (deductibles and coinsurance) billed by the physician, facility or pharmacy, or you can choose to save your HSA dollars for a future medical expense.

What is a deductible?
It is a set dollar amount determined by your plan that you must pay out-of-pocket or from your HSA account, before insurance coverage for medical expenses can begin.

How much can I contribute to an HSA?
As noted by federal law, the annual contribution limits are:
- $3,050 for 2010 and 2011 for individual coverage or $6,150 for family coverage.
Individuals age 55 or older may be eligible to make a catch-up contribution of $1,000.

What is the difference between an HSA and Flexible Spending Account (FSA)?
- An HSA can roll over unused funds from year to year.
- An FSA cannot roll over unused funds from year to year.

Can I contribute to both an HSA and an FSA in the same year?
Yes, a “limited FSA” is permissible. A limited FSA only allows reimbursement of expenses that are not eligible for payment under the HDHP or HSA. For example, an employer may establish a limited FSA to allow employees to contribute pre-tax dollars to an account which only reimburses expenses for dental services. Please ask NP Dodge Insurance if a limited FSA is available to you.
If you are covered under an FSA plan that includes a grace period, you are eligible to establish an HSA in the following year if your FSA had a zero balance at the end of the plan year or if you transfer your unused balance into the HSA at the end of the FSA plan year.

What if I enroll in an HSA in the middle of the year?
If you enroll in an HSA mid-year, you are allowed to make a full year’s contribution, provided that you remain covered by the HSA for at least the 12-month period following that year.
Why should I elect an HSA?

1. **Cost Savings**
   - Tax benefits
     - HSA contributions are excluded from federal income tax
     - Interest earnings are tax-deferred
     - Withdrawals for eligible expenses are exempt from federal income tax
   - Reduction in medical plan contribution
   - Unused money is held in an interest-bearing savings or investment account

   *Note:* Many states have not passed legislation to provide favorable state tax treatment for HSAs. Therefore, amounts contributed to HSAs and interest earned on HSA accounts may be included on the employee’s W-2 for state income tax purposes.

2. **Long-Term Financial Benefits**
   - Save for future medical expenses
   - Funds roll over from year to year
   - This is your account – you take it with you

3. **Choice**
   - You control and manage your health care expenses.
   - You choose when to use your HSA dollars to pay your health care expenses.
   - You choose when to save your HSA dollars and pay health care expenses out-of-pocket.
ABC Company
2010 Benefits Statement

January 1, 2010

Dear Joe Smith:

This personal benefits statement is a brief outline of the benefits ABC Company provides to you. It summarizes each benefit and illustrates the significance of your benefits package as part of your total compensation. Please review the information carefully and direct any questions to Jane Doe at (414) 444-4444 ext. 232.

<table>
<thead>
<tr>
<th>Personal Information:</th>
<th>Employment Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSN: 088-88-8888</td>
<td>Date of Hire: January 1, 2002</td>
</tr>
<tr>
<td>Name: Joe Smith</td>
<td>Annual Base Salary: $37,562.00</td>
</tr>
<tr>
<td>Address: 123 Main Street</td>
<td>Job Title: Electrician</td>
</tr>
<tr>
<td>City, State, Zip: Whitewater, WI 53190</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Name:</th>
<th>Benefit Description:</th>
<th>Annual Cost:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>UnitedHealth care Choice</td>
<td>$4,684.42</td>
</tr>
<tr>
<td>Dental</td>
<td>MetLife Dental Plan</td>
<td>$360.88</td>
</tr>
<tr>
<td>Vision</td>
<td>Vision Service Plan Discount Card</td>
<td>$0.00</td>
</tr>
<tr>
<td>Employer-provided Short-term Disability</td>
<td>Company Provided STD benefit equal to 60% of your weekly rate for maximum benefit period of 13 weeks</td>
<td>$125.10</td>
</tr>
<tr>
<td>Employer-provided Long-term Disability</td>
<td>Company provided LTD monthly benefit begins after 90 days of total disability. Benefit equivalent to 70% of basic monthly earnings while disabled up to age 65.</td>
<td>$210.20</td>
</tr>
<tr>
<td>Employer-provided Basic Life &amp; AD&amp;D</td>
<td>One times salary to maximum benefit of $100,000</td>
<td>$174.10</td>
</tr>
<tr>
<td>Voluntary/Supplement Life</td>
<td>No Coverage</td>
<td>$0.00</td>
</tr>
<tr>
<td>Dependent Life</td>
<td>No Coverage</td>
<td>$0.00</td>
</tr>
<tr>
<td>Voluntary Long-term Care</td>
<td>Base plan covers $1,000 per month facility for 3 years or $500 per month homecare for 6 years.</td>
<td>$0.00</td>
</tr>
<tr>
<td>Health Care Spending Account</td>
<td>2009 Contribution</td>
<td>$0.00</td>
</tr>
<tr>
<td>Dependent Care Spending Account</td>
<td>Paid Yearly</td>
<td>$0.00</td>
</tr>
<tr>
<td>Commuter Expense Reimbursement Account</td>
<td>Paid Yearly</td>
<td>$0.00</td>
</tr>
<tr>
<td>401(k) Plan</td>
<td>Can elect to defer up to 25% of your income pretax. Company match is 50% of withholdings up to 4%.</td>
<td>$1,302.48</td>
</tr>
<tr>
<td>Profit sharing</td>
<td>Determined annually by board of directors based on profitability</td>
<td>$650.54</td>
</tr>
<tr>
<td>Employee Stock Purchase Plan</td>
<td>Shares of company stock can be purchased 2 times annually with a 15% discount (see plan document for more details).</td>
<td>$0.00</td>
</tr>
<tr>
<td>FICA Tax</td>
<td></td>
<td>$2,490.99</td>
</tr>
<tr>
<td>Federal Unemployment</td>
<td></td>
<td>$56.00</td>
</tr>
<tr>
<td>State Unemployment</td>
<td></td>
<td>$131.25</td>
</tr>
<tr>
<td>Workers’ Compensation</td>
<td></td>
<td>$83.20</td>
</tr>
</tbody>
</table>
Total Benefits Cost: $10,269.16  
Plus Annual Base Salary: $37,562.00  
**TOTAL COMPENSATION:** $47,831.16  

Cost of employer-sponsored benefits as a percentage of total compensation 21.5%

**Miscellaneous Benefits:**

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>401(k) and Profit Sharing</strong></td>
<td>ABC Co. is pleased to partner with you in providing for your retirement. Our tax-deferred 401(k) plan offers you many advantages over a typical savings account. With a 401(k) plan, the money you put in the account is tax-deferred. Additionally, the interest you earn on the money in your account grows without having taxes withheld, so the total grows much quicker than it would without this tax advantage.</td>
</tr>
<tr>
<td><strong>Bereavement Pay</strong></td>
<td>We have taken into consideration the personal needs which arise from the death of an immediate family member. Up to 5 days off may be granted with pay.</td>
</tr>
<tr>
<td><strong>Credit union membership</strong></td>
<td>As an employee you are eligible for membership in the Southeastern State Credit Union. See HR for details.</td>
</tr>
<tr>
<td><strong>Direct Deposit</strong></td>
<td>Direct Deposit to your financial institution is available for our convenience. See HR for details.</td>
</tr>
<tr>
<td><strong>Employee Assistance Program</strong></td>
<td>An employee assistance program is available for all employees and their families for confidential assistance in dealing with personal concerns.</td>
</tr>
<tr>
<td><strong>Paid Holidays</strong></td>
<td>ABC Co. recognizes 10 paid holidays each year, typically: New Year's Day and the day before or after; President's Day; Memorial Day; Independence Day; Labor Day; Thanksgiving Day and the day following; and Christmas Day and the day before or after.</td>
</tr>
<tr>
<td><strong>Jury Duty Pay</strong></td>
<td>If you are chosen for jury duty you will be provided with your regular pay minus any compensation from the court for up to 10 working days.</td>
</tr>
<tr>
<td><strong>Onsite Child Care</strong></td>
<td>Contact Great Kids at (800) 555-5555 for information.</td>
</tr>
<tr>
<td><strong>Severance Pay</strong></td>
<td>Negotiated upon hire.</td>
</tr>
<tr>
<td><strong>Paid Sick Days</strong></td>
<td>Our sick leave policy is established to assist you when you are unable to work due to illness, injury, or a medical condition.</td>
</tr>
<tr>
<td><strong>Tuition Reimbursement</strong></td>
<td>100% reimbursement of tuition and course-required books for classes pertinent to present position or next logical step. Course must be from accredited school, college or university. Reimbursement not to exceed $1500 annually.</td>
</tr>
<tr>
<td><strong>Uniform Expense</strong></td>
<td>$200 annually is allowed for purchase of uniforms.</td>
</tr>
<tr>
<td><strong>Vacation</strong></td>
<td>Each employee earns 10 days of vacation in the first year of employment. One vacation day is added for each additional year of employment up to a maximum of 25 days per year.</td>
</tr>
<tr>
<td><strong>Voting Leave</strong></td>
<td>ABC Co. provides up to 2 hours to vote in both the primary and general elections held each year.</td>
</tr>
<tr>
<td><strong>Wellness Program</strong></td>
<td>Up to $100 annually for eligible wellness classes, health club membership or weight loss program. See HR for program details.</td>
</tr>
</tbody>
</table>

Please contact Human Resources with any questions or comments about your personal benefits summary. ABC Company is pleased to be able to offer these valuable benefits to you, and we thank you for being a partner in our success.

Every effort has been made to ensure that the information in this statement is accurate; however no warranty of complete accuracy is made. This report does not in any way constitute a contract of employment. ABC Company reserves the right to amend pay and benefits at any time without notice. If you feel an error has been made or have any questions, please contact Human Resources.
In addition to general day-to-day services, we will release a Request for Proposal to the marketplace in order to review all your vendor options now and at renewal. Evaluating, negotiating with, and recommending insurers and providers to our clients are specialties. Our position in the marketplace allows us to enjoy preferred financial arrangements with insurance vendors and third party administrators across the United States. We actively cultivate long-standing relationships with major carriers, and those relationships allow us to negotiate aggressively and obtain cost-efficient proposals for our clients.

As we negotiate with vendors, we will also examine your loss history, establish the necessary types of coverage consistent with your risk tolerance, choose carriers that provide superior services and adopt the optimal funding mechanisms for your specific needs.

We have established rigorous selection criteria for potential vendors, and recommend a selection based on the following considerations.

**Critical Vendor Selection Criteria**
- Overall service and quality
- Experience in administering network-based programs
- Commitment to continuous quality improvement processes
- Experience in administering multiple option health programs
- Quality of communication materials (booklets, EOBs, etc.)
- Effective administration procedures (coordination of benefits, subrogation, etc.)
- Responsiveness of group representative
- Cost efficiency
- Responsiveness to client feedback
- Professionalism of response to RFP
- Willingness to adapt to changing needs and circumstances
- Adequate staffing ratios
- Superior network coverage in relation to location your employees
Employee’s awareness of their health condition is essential to identifying the most prevalent chronic diseases: cancers, strokes, heart disease and diabetes. Early detection and treatment of these conditions and the underlying risk factors are the most important steps employers can take to control long-term healthcare costs. The undetected development of chronic disease leads to high-cost illnesses.

*Maximum HEALTH Solutions* goes beyond a traditional wellness program by integrating a health risk assessment with targeted intervention by healthcare professionals. Educating and motivating employees to become involved in and responsible for their health is one of the most important steps to achieving healthy lifestyles.

*Maximum HEALTH Solutions* features include:

**Health Risk Assessment:** Confidential online questionnaire helps to analyze lifestyle choices, medical history, safety, nutrition, physical activity, stress levels and readiness to improve overall health habits.

**Annual Health Screenings:** Annual screenings provide important information regarding personal health risks for serious illness or chronic conditions.

- Blood Pressure
- Height/Weight
- Body Mass Index
- Laboratory tests (venipuncture) for:
  - Complete Blood Count
  - Blood Chemistry—blood sugar and other electrolytes
  - Lipid Panel—Cholesterol levels and Triglycerides
  - U-TSH—thyroid hormone levels (optional)
  - PSA—Prostate Specific Antigen (optional)

**Reporting:** Confidential Employer Report & Personal Profile Employee Reports are provided.

**Quarterly Health Coaching:** Telephone consultation with one-on-one meetings with healthcare professionals are provided to establish self-management strategies for improved health.
Employer Reporting

Confidential aggregate reports for the employer. This is a document that provides detailed information as to the state of health in your population.
Personal Health Profile

Confidential aggregate report is provided to each participant. This provides specific information as to the health and lifestyle of each employee.
Control Rising Costs.  
Increase Productivity and Morale.

Your Workplace Wellness Partner

Our agency can deliver resources that you need to effectively create a healthy and happy employee culture. Our tools will help you create and administer a wellness program at your organization with minimal investment of time and money.

Our Tools for Your Success

Our agency can help you create a wellness program that will help you control rising health care costs, increase employee productivity and increase employee morale.

Customized to fit your needs

Whether it's a simple monthly wellness newsletter or a comprehensive plan, we'll help you develop a program that fits your needs.

Data Analysis

We have tools to help you gather claims data, conduct a needs-and-interest survey, and audit your current wellness culture, all to help pinpoint your employee group health needs.

The Seven Cs

Whether it's a simple wellness newsletter or a comprehensive plan, we will help you develop a wellness program that suits your needs and guides you through your efforts. Our article will advise you on how to:

• Capture senior-level support
• Create a wellness team
• Collect data
• Craft an operating plan
• Choose health initiatives
• Create supportive environment
• Consistently evaluate outcomes

Custom Communication to Your Employees

Speak to your employees through educational materials that meet your wellness needs. We have documents that will help them understand their health issues and make wise decisions to benefit their lives now and in the future. These include posters, payroll stuffers, communications flyers and e-mails.
Workplace Wellness: Why Promote Wellness?

Wellness issues important to you – brought to you by the insurance specialists at NP Dodge Insurance.

What is Workplace Wellness?

Workplace wellness refers to the education and activities that a worksite may do to promote healthy lifestyles to employees and their families. Examples of wellness programming include such things as health education classes, subsidized use of fitness facilities, internal policies that promote healthy behavior, and any other activities, policies or environmental changes that affect the health of employees. Wellness programs can be simple or complex. Many programs require a minimal investment of time and money. More substantial programs often use more resources, but the many benefits to supporting and encouraging employee health and safety outweigh the costs.

Why Workplace Wellness?

It affects your company’s bottom line in many ways. Here are three key factors:

- Decreased healthcare costs
- Increased productivity
- Better morale

Rising healthcare benefit costs are a significant concern, and poor health habits and unnecessary medical care costs consume portions of our corporate resources as well as the employee paycheck. The worksite is an ideal setting for health promotion and disease prevention programs. Employees spend many of their waking hours at work, nearing 50 hours per week. That’s why the workplace is an ideal setting to address health/wellness issues.
Why Start a Company Wellness Program?

**Wellness programs help control costs**

An investment in your employees' health may lower healthcare costs or slow the increase in providing that important benefit. In fact, employees with more risk factors, including being overweight, smoking and having diabetes, cost more to insure and pay more for health care than people with fewer risk factors. An employee wellness program can raise awareness so employees with fewer risk factors remain in a lower-cost group. A program also can encourage employees with health risk factors to make lifestyle changes to improve their quality of life and lower costs. The payoff in dollars as well as in quality of life can have a big impact on your company’s bottom line.

**Increase productivity**

Healthier employees are more productive. This has been demonstrated in factory settings and in office environments in which workers with workplace wellness initiatives miss less work. Presenteeism, in which employees are physically present on the job but are not at their most productive or effective, is reduced in workplaces that have wellness programs.

**Reduce absenteeism**

Healthier employees miss less work. Companies that support wellness and healthy decisions have a greater percentage of employees at work every day. Because health frequently carries over into better family choices, your employees may miss less work caring for ill family members as well. The cost savings of providing a wellness program can be measured against reduced overtime to cover absent employees and other aspects of absenteeism.

**Improve morale and enhanced image for the organization**

A company that cares about its employees' health is often seen as a better place to work. Those companies save money by retaining workers who appreciate the benefit of a wellness program and they can attract new employees in a competitive market.
2009 Wellness Benefits Survey Results

Workplace wellness continues to be a hot topic, as there are many different types of wellness programs. The essence of these programs is to encourage employees to take preventive measures to avert the onset or worsening of an illness or disease, and to adopt healthier lifestyles.

Employers may utilize a wide range of wellness initiatives, from onsite gyms to simple wellness newsletters. You can achieve savings and increased productivity with just a few simple activities that promote healthy behaviors. What’s important is getting started. Having a plan, along with one or two health promotion activities, can serve as a foundation for a more comprehensive program down the road. If your company isn’t participating yet, these results might help you think about your next steps.

This survey was intended to uncover the trends in current wellness programs, along with gauging future employer needs, as more companies utilize this strategy as a portion of the overall health plan.

A total of 1163 respondents completed this survey.

Demographic Information

In which region is your organization based (the most employees)?

[Map showing distribution of regions with various percentages indicated on states]

In which industry/sector does your organization operate?

[Bar chart showing distribution of industries with percentages indicated]

How many employees does your organization have?

[Bar chart showing distribution of employee counts with percentages indicated]

What is your organization’s annual revenue?

[Bar chart showing distribution of revenue ranges with percentages indicated]
Almost one hundred percent of respondents are offering health benefits to their employees. Of those, sixty percent are likely to ask their employees to pay more for their health insurance in 2010. Fifty-five percent of respondents find workplace wellness programs to be at least a somewhat effective way of helping employers to control the increasing costs of health insurance.

**Are you offering health benefits to your employees?**

- Yes: 98%
- No: 2%

**Indicate the likelihood of making the following changes to your health plan in the next year.**

<table>
<thead>
<tr>
<th>Change in Health Insurance Costs</th>
<th>Very Likely</th>
<th>Somewhat Likely</th>
<th>Not Too Likely</th>
<th>Not At All Likely</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the amount employees pay for health insurance</td>
<td>29%</td>
<td>31%</td>
<td>19%</td>
<td>16%</td>
<td>5%</td>
</tr>
<tr>
<td>Increase the amount employees pay for deductibles</td>
<td>15%</td>
<td>28%</td>
<td>32%</td>
<td>21%</td>
<td>4%</td>
</tr>
<tr>
<td>Increase the amount employees pay for office visits, copays or coinsurance</td>
<td>11%</td>
<td>27%</td>
<td>36%</td>
<td>21%</td>
<td>5%</td>
</tr>
<tr>
<td>Increase the amount employees pay for prescription drugs</td>
<td>7%</td>
<td>25%</td>
<td>40%</td>
<td>22%</td>
<td>6%</td>
</tr>
<tr>
<td>Restrict employees’ eligibility for coverage</td>
<td>2%</td>
<td>4%</td>
<td>32%</td>
<td>58%</td>
<td>4%</td>
</tr>
<tr>
<td>Drop coverage completely</td>
<td>0%</td>
<td>1%</td>
<td>11%</td>
<td>83%</td>
<td>4%</td>
</tr>
<tr>
<td>Introduce tiered networks for office visits or hospital stays</td>
<td>3%</td>
<td>9%</td>
<td>32%</td>
<td>41%</td>
<td>15%</td>
</tr>
<tr>
<td>Offer high deductible health plan with a health reimbursement arrangement (HRA)</td>
<td>16%</td>
<td>15%</td>
<td>22%</td>
<td>38%</td>
<td>9%</td>
</tr>
<tr>
<td>Offer HSA-qualified high deductible health plan</td>
<td>20%</td>
<td>10%</td>
<td>21%</td>
<td>39%</td>
<td>10%</td>
</tr>
</tbody>
</table>

**Rate how effective the following strategies are in reducing the growth of health insurance costs.**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Very Effective</th>
<th>Somewhat Effective</th>
<th>Not Too Effective</th>
<th>Not Effective At All</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workplace wellness programs</td>
<td>11%</td>
<td>44%</td>
<td>18%</td>
<td>3%</td>
<td>24%</td>
</tr>
<tr>
<td>Disease management programs</td>
<td>10%</td>
<td>41%</td>
<td>17%</td>
<td>3%</td>
<td>29%</td>
</tr>
<tr>
<td>Consumer-driven health plans (ex: HDHP combined with an HSA)</td>
<td>9%</td>
<td>30%</td>
<td>18%</td>
<td>5%</td>
<td>38%</td>
</tr>
<tr>
<td>Higher employee cost-sharing</td>
<td>8%</td>
<td>37%</td>
<td>26%</td>
<td>8%</td>
<td>21%</td>
</tr>
<tr>
<td>Tighter managed care networks</td>
<td>4%</td>
<td>28%</td>
<td>26%</td>
<td>7%</td>
<td>35%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>6%</td>
<td>4%</td>
<td>13%</td>
<td>3%</td>
<td>74%</td>
</tr>
</tbody>
</table>
Your Wellness Program

There is a high level of interest toward wellness programs – 76 percent of respondents are currently utilizing or considering a wellness program, up from 72 percent last year. The top two reasons for implementing a wellness program are improved employee health/reduction in absenteeism and a decrease in health care costs, in line with last year’s findings. Sixty-three percent expect a reduction of health care costs resulting from the implementation of a wellness program. Seventy-three percent of all respondents believe their wellness program has been successful in improving the overall health of their employees. The most popular workplace wellness programs include: health risk assessments, weight management programs and distributing a health/wellness newsletter.

Has your organization moved toward a focus on improving employee health through wellness programs?

- Yes: 33%
- No: 43%
- Considering but have not implemented: 24%

Do you expect that your wellness program will reduce your overall health care costs?

- Yes, we expect results in the next year: 17%
- Yes, but not immediately: 47%
- Possibly, but there were other reasons that motivated us: 27%
- No, we do not expect a measurable impact: 9%
What top three factors influenced your decision to implement a workplace wellness program?

- Improved employee health/reduce absenteeism: 88%
- Reduce health care costs: 77%
- Improved employee morale and productivity: 58%
- Reduce the cost of benefits other than health care: 19%
- Wellness benefits were a part of health plan: 18%
- Reduce workers’ compensation claims: 12%
- Improve recruitment/retention: 9%
- Other: 5%

If you have seen a reduction in costs as a result of your wellness initiative, where have you realized a savings?

- Haven't seen savings yet: 72%
- Reduced absenteeism: 16%
- Lower overall health care costs: 13%
- Productivity improvement: 12%
- Fewer doctor office visits: 9%
- Lower prescription drug costs: 6%
- Lower WC costs/claims: 5%
- Lower disability costs: 4%

Do you think your wellness program has been successful in improving the overall health of employees?

- Yes: 73%
- No: 27%

Contact NP Dodge Insurance to discuss how this survey information can assist you in your future benefit plan strategies.
Sample Employee Wellness Posters

Are You Getting a Regular Dose of Fiber?

A recent study conducted at the University of Texas at Austin revealed that consuming fiber can have major positive effects on your wellbeing.

- Fiber-rich foods like beans and nuts can significantly reduce the risk of heart disease and cancer. It's crucial to incorporate fiber into your diet.
- Eat at least 25 grams of fiber each day, which includes fruits, vegetables, and grains. A diet rich in fiber helps you feel full for longer.

The Benefits of Participating in Our Company’s Wellness Program

What can our wellness program do for you?

- We provide resources to help you achieve your health and weight loss goals.
- We offer incentives to motivate you to stay on track and achieve your goals.
- We provide support and encouragement to keep you going.

Rise and shine...it's time to eat breakfast!

Even though you may not be a morning person, in the morning, it is wise to eat breakfast within two hours of waking up. Here are some of the benefits of having a morning meal:

- Breakfast controls weight and binge eating throughout the day.
- Breakfast eaters have more strength and endurance, sharper concentration, and better problem-solving abilities.
- People who eat a morning meal consume more vitamins, minerals, and other healthy nutrients.
- Breakfast eaters consume less fat and cholesterol than non-breakfast eaters.
- People who eat breakfast have lower blood cholesterol, which can reduce the risk of heart disease.

Eat Breakf!t

It’s Time to Shoo the Flu!

Every year, between five and 33 percent of the U.S. population will get the flu, according to the CDC. Here’s how to prevent it and how to recover faster:

What are symptoms of the flu?
- Sudden onset of fever
- Headache
- Muscle aches
- Fatigue
- Stomach pain or nausea
- Diarrhea
- Irritable and stuffy nose

What can you do to prevent the flu?
- Wash your hands often
- Cover your mouth and nose when you cough or sneeze
- Avoid close contact with people who are sick
- Avoid poultry and eggs
- Avoid touching your eyes, nose, and mouth

An Apple a Day

Truly CAN keep the doctor away! Apples contain nutrients and vitamins that may actually work to prevent disease. Here are the facts:

- Apples are nutritious and are known to contain many nutrients and vitamins that can boost your immune system.
- Apples are low in calories and can help control your weight.
- Apples are high in fiber and can help improve digestive health.

MAP it Out

Need a guide on your path to fitness success? Here’s the ticket: log on to www.prevention.com/newwalkingmaps/mainl.html.

- If you enjoy your morning walk, this is the perfect tool to help you achieve your fitness goals.
- This tool allows you to create a walking or running route in your area. In addition to its ability to create a customized route, you can track your distance, pace, and calories burned.
- You can even track your progress over time and set goals for yourself.

FILL UP on FIBER

Eat Breakf!t

Shoo the FLU

An Apple a Day
As employers are looking for long-term solutions to help control cost, we at NP Dodge Insurance offer programs to help manage your risk. With these programs we work to identify root causes of health risks in your population and attack those with specific programs designed for your employees.

Please contact our office to discuss reducing your risk and achieving long term goals for you & your company.

**Shane Jacobsen**  
Vice President, Employee Benefits  
Phone: 402.938.5011  
Cell Phone: 402.306.5008  
Fax: 402.938.5090  
sjacobsen@npdodge.com

**Tracy Petersen**  
Employee Benefits Manager  
Phone: 402.938.5053  
Cell Phone: 402.980.1924  
Fax: 402.938.5090  
tpetersen@npdodge.com

12002 Pacific Street  
Omaha, NE 68154  
(402) 938.5008  
npdodgeinsurance.com